Washington State Department of Social & Health Services

MENTAL HEALTH EVALUATION AND TREATMENT APPLICATION FOR CERTIFICATION

1. APPLICATION TYPE
☐ New
☐ Renewal.

Complete one application per facility. Use this application to establish or renew certification for the following components of a county's evaluation and treatment program:

- Emergency Crisis Intervention Services: (WAC 388-865-0468): In order to provide emergency services to a consumer who may need to be detained or who has been detained, the service provider must be licensed for emergency crisis intervention services and be certified by the Mental Health Division to provide involuntary treatment services consistent with WAC 388-865-0484.
- Outpatient Certification: (WAC 388-865-0466): In order to provide services on a less restrictive alternative court order, providers must be licensed to provide the psychiatric and medical service component of community support services and be certified by the Mental Health Division to provide involuntary treatment services consistent with WAC 388-865-0484.
- Inpatient Evaluation and Treatment Facilities: (WAC 388-865-0500): The Mental Health Division certifies facilities to provide involuntary inpatient evaluation and treatment services for more than 24-hours. Facilities must be certified in order to provide services to consumers who are authorized by regional support network or mental health prepaid health plan to receive psychiatric inpatient evaluation and treatment services on an involuntary basis.
- Evaluation and Treatment Facility Certification: (WAC 388-865-0505): To gain and maintain certification to provide inpatient evaluation and treatment services under Chapter 71.05 and 71.34 RCW, a facility must meet applicable local, state, and federal laws and regulations including Department of Health licensure requirement and WAC 388-865-500 through 388-865-560.

2. COUNTY	3. REGIONAL SUPPORT NETWORK (RSN)/COUNTY DESIGNATED ADMINISTRATOR'S NAME	4. TELEPHONE NUMBER (INCLUDE AREA CODE)

5. ADDRESS	CITY	STATE	ZIP CODE

6. CERTIFICATION COMPONENT TYPE

☐ Emergency Crisis Intervention Services
☐ Outpatient Certification
☐ Inpatient Evaluation and Treatment Facilities
☐ Evaluation and Treatment Facility Certification

☐ Adults
☐ Children

7. FACILITY NAME

8. ADDRESS	CITY	STATE	ZIP CODE

9. ADMINISTRATOR'S NAME	10. TELEPHONE NUMBER (INCLUDE AREA CODE)

11. LEGAL STATUS (CHECK ONE)

☐ Individual
☐ Proprietary Corporation
☐ Governmental Agency
☐ Partnership
☐ Non-Profit Corporation

12. HEALTH SERVICES LICENSING STATUS

DATE LICENSE ISSUED

13. My signature represents Regional Support Network approval of this application. I will notify the department of observations that this provider may not be in compliance with licensing requirements.

14. RSN/COUNTY ADMINISTRATOR'S SIGNATURE	DATE

RETURN COMPLETED APPLICATION ORIGINAL TO:
DSHS MENTAL HEALTH DIVISION
QUALITY ASSURANCE AND IMPROVEMENT SECTION
PO BOX 45320
OLYMPIA WA 98504-4320